STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
BUREAU OF ELDER AND ADULT SERVICES
442 CIVIC CENTER DRIVE
11 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0011

John Elias Baldacci
Governor

MaineCare Home Health Referral Attachment (Age 21 and over)

Member: ________________________________

MaineCare #: ☐☐☐☐☐☐☐☐☐

◆◆

Section 40.02-3

☐ Attached is the Form HCFA-485 Plan of Care signed by the member's physician. The member's physician signed and certified a plan of care that safely and appropriately treats the member's medical condition. **OR**

☐ Attached are physician orders for the plan of care at time of discharge. The member is located in a hospital.

AND

☐ These services are not available and safely accessible to the member on an outpatient basis.

☐ Medically contraindicated with likelihood of a bad result.

Specify reason: ____

____. **AND**

☐ The member's condition requires skilled nursing care on a "part-time" or "intermittent" basis, or physical, occupational, or speech therapy as defined in Section 40.02-3 (E).

Prior Authorization required: Check the category of service that you are requesting Goold Health Systems to prior authorize for this member.

☐ Member requires additional certification period for continued assessment and management of skilled services as defined in Section 40.06-E. **Start of Care Date:** ___/___/___

☐ Member requires additional certification period for continued teaching and training, as defined in Section 40.06-E. **Start of Care Date:** ___/___/___

☐ Member requires continued home health services.

☐ Member appears to be Nursing Facility level of care.

☐ Prior Authorization is needed to add additional services to Section 17 plan of care.

Person completing this form: ________________________________ **Date:** __________

Provider Name: ____

HH Referral-BEAS 7_1_03

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